There has been a significant increase in those persons covered by hospital expense benefits; this reverses an earlier trend which showed that during 1961 regular medical expense coverage experienced a faster growth rate than did either hospital or surgical coverage.

Major medical expense insurance, the fastest growing type of voluntary health insurance in the United States, covered 38.2 million persons at the end of December, 1962. No state breakdowns are available, but if the same proportion of persons in California are enrolled under this program as are under those for hospital expense, it can be estimated that over three million persons in California have such coverage.

Since these figures and per cents are gross and do not represent an evaluation of coverage in terms of an available market for voluntary health insurance, perhaps a few comments are in order to place the data in somewhat finer perspective. Aside from those persons who, for personal reasons, do not desire voluntary health insurance coverage, a large number and a significant per cent of those not coming under voluntary health insurance coverage are provided with health care services, or have such services financed for them. These would include—but are not limited to—persons eligible for care through the U.S. Public Health Service, such as American Seamen; those persons eligible for care such as veterans whose care in many cases is for non-service connected conditions; persons who receive care under vocational rehabilitation; people eligible for care under California's Public Assistance Medical Care Program; Armed Forces Personnel and dependents covered in the Medicare Program; the services provided under the Crippled Children's Program administered by the State Department of Public Health; and last but not least, persons who have no other type of coverage but who are covered by Disability Insurance Hospitalization Benefits, administered by the State Department of Employment.

It is estimated that between 40 per cent to 50 per cent of the remaining five million persons in California not covered by voluntary health insurance have some other type of health care protection. Thus a higher per cent of the population in California has health care service programs available to them than is reflected just in the enrollment under voluntary health insurance programs.

693 Sutter Street, San Francisco, California 94102.

Health Care for the Aged

I AM DR. HENRY S. BLAKE, and I am engaged in the private practice of medicine in Topeka, Kansas. I am appearing here today as Chairman of the Board of Directors of the National Association of Blue Shield Plans. Accompanying me is Mr. John W. Castelluci, Executive Vice President of the Association.

The National Association of Blue Shield Plans is the coordinating organization of the Blue Shield Medical Care Plans which now provide prepaid medical and surgical care benefits to 49 million people throughout the United States. The Association has 71 Member Plans. The Association's main purpose is to help its Member Plans do a continuously better job for the people in their respective areas, and to foster public and professional support for the voluntary, nonprofit, community-sponsored medical care prepayment program.

The Blue Shield name and symbol is a respected and nationally recognized service mark. It identifies those prepayment Plans which are endorsed by the medical profession and which offer benefits specifically related to the medical needs and resources of their local communities. As part of its continuing effort to improve these programs, the National Association of Blue Shield Plans requires each Member Plan to reapply for membership each year, and to meet certain standards of quality and performance.

Blue Shield and Blue Cross share a common objective—to make available a comprehensive medical and hospital prepayment service to the entire population. Blue Shield is engaged in covering physicians' services, while Blue Cross is devoted to the payment of hospital services. Although the local Blue Cross and Blue Shield Plans work in close cooperation in most parts of the country, they are distinctly separate organizations, both locally and nationally.

The leaders of Blue Shield and of the medical community have recognized that aging people present special problems in respect to their needs for medical care—just as do many other particular segments of the population such as the chronically ill, the handicapped, and the indigent. One of the chief distinctions of Blue Shield Plans is that they have always sought to bring the resources of the entire community to bear upon the problems of each of its component groups.

The growth of Blue Shield is an impressive demonstration of the growing national concern to make adequate prepayment mechanisms for medical care available to all who need such help—regardless of

A Statement before the Committee on Ways and Means, United States House of Representatives, by Henry S. Blake, M.D., Chairman of the Board of Directors, National Association of Blue Shield Plans, January 23, 1964.

age. The various bills now before your committee are further manifestations of this concern. And the Kerr-Mills Act is evidence of Congressional competence to deal effectively and wisely with the medical care problems of our aging citizens. It is clear that a deep and constructive interest in medical care for the aged is not the exclusive property of those who favor HR 3920.

For many years the profession has been moving steadily—in the development of Blue Shield and along many other lines—to meet these needs not only for the aged, but for all the members of the community.

Blue Shield membership now includes approximately 4 million citizens past 65 years of age, and our programs permit everyone to continue his Blue Shield coverage as he passes the age of 65. This means that a constantly growing proportion of America's working population can look forward confidently to a continuation of their medical care prepayment programs when they reach retirement age.

In the process of Blue Shield's growth, it has naturally become ever more involved with the health care problems of the aged. In 1951, 5% of all Blue Shield members, or nearly 1 million persons, were 65 years of age or older. By 1959, this number had grown to more than 2½ million persons representing 6.4% of all Blue Shield members, and our present Blue Shield membership of 4 million persons over 65 represents 8.2% of our entire membership. It is particularly significant that while total Blue Shield membership during the past 18 months has increased about 5½%, the number of persons over age 65 covered by Blue Shield has increased 21%. Thus, the growth rate of coverage of older persons is now nearly four times the growth rate of all age groups combined. This is accounted for by the fact that Blue Shield is offering a good program, a constantly improving program, and is aggressively selling it.

In 1959, only 10 Plans offered individual non-group membership without age limit. Today, 69 of the 71 U.S. Blue Shield Plans, representing over 99% of the total U.S. Blue Shield membership, have available individual non-group coverage for persons over 65.

A distinctive characteristic of most Blue Shield Plans has always been the provision of benefits on a fully paid "service benefit" basis, particularly for Blue Shield subscribers in the medium and lower income brackets.

Through the service benefit feature, which is now embraced to some degree by nearly all Blue Shield Plans, the local physicians enter into a voluntary—but binding—agreement with their local Plans to accept Plan payment for all covered services, provided the income of the subscriber falls within certain locally specified income levels.

The service benefit feature has been applied to Blue Shield senior citizen programs even more completely than to the programs for other age groups. Of the 69 Blue Shield Plans that now offer a special senior citizen program, 61 of them provide benefits on a fully prepaid service basis to the senior citizens of low income.

Apart from the remarkable progress made in providing health insurance coverage on an individual basis to those 65 and over, an even more significant development has been the increasing practice of both local and national labor and management groups to negotiate a provision in their health and welfare program for the continued coverage of retired employees under the same arrangements and conditions—the same rates and benefits—as have been established for active employees. The best example is the pattern adopted by the Federal Government for its own retiring employees. I'm sure you know that Blue Shield and its companion hospital Plan, Blue Cross, cover well over 1,150,000 Federal employees plus the members of their families for a total of approximately 3½ million people. Each year more than 25,000 retiring Federal employees take their Blue Shield protection into retirement. As retirees, these Federal employees, like many retiring from private industry, are assisted by their former employer in continuing their health coverage.

And just as the States and the Federal Government match funds to provide medical care for the aged who are medically indigent, so the solvent individual and his employer, by matching funds in this manner, make possible the continuation of medical progress under the voluntary system.

But our enrollment of older people in Blue Shield and Blue Cross Plans is only a part—though a very major part—of the volume of medical care protection now voluntarily supported by those in the age groups over 65. Some $8 billion was invested by Americans last year in voluntary health insurance and $3.2 billion of this was invested in Blue Shield and Blue Cross. It is pretty evident that the people of the United States like the voluntary approach to this problem!

It is also clear that a significant and growing proportion of the over 65 population can and will provide for their medical needs through programs of their own choice—once such programs are readily available to them. And it is equally clear that acceptable programs are now much more readily available to the elderly than ever before.

The public acceptance of prepayment through Blue Shield has been phenomenal. The growth of

voluntary health insurance has astounded its friends and confounded its critics.

In the brief span of 23 years, marked by war, recession, and inflation, Blue Shield membership has grown from 370,000 to 49 million and the total number of people covered by voluntary health insurance has grown from 12 million to more than 145 million, which represents 77% of the entire U.S. population.

These achievements offer reassurance for the future. There is every reason to expect that the proportion of the over 65 population covered by voluntary health insurance will soon match the percentage of the total population covered by voluntary health insurance, and that both the quantity and quality of coverage for those on both sides of the 65 year line will continue to improve at a rapid pace.

In short, gentlemen, we are dealing with a problem which from day to day is progressively finding a more adequate solution through voluntary methods—through the cooperative mechanisms established by those who wish to obtain and those who stand ready to provide medical care. Conversely, as the pace and degree of the private solution of this problem increases, the residue which requires governmental assistance proportionately grows smaller and smaller from day to day. The problem of financing health care for the aged is a diminishing problem.

Under "Findings and Declaration of Purpose," HR 3920 starts out by having Congress find as a fact that, "the heavy costs of hospital care and related health care are a grave threat to the security of aged individuals." We challenge the accuracy of this statement. We who have pioneered the voluntary health care movement are the first to acknowledge that there will always be some people in all age groups who cannot purchase the medical care they need through their own resources. This relatively small group of people must be, to some degree, a responsibility of the community.

However, it seems wholly illogical to provide for the few whose need is real by embracing the many who do not need help, through the duplicative and costly device proposed in HR 3920. It is equally tragic to enact any program which would supplant or jeopardize the accomplishments of the voluntary cooperative program of which Blue Shield is an important component.

We believe—indeed, I'm sure that all of us believe —that people of *any* age who need help in availing themselves of medical care should and must have help. If today, Blue Shield and Blue Cross were suddenly eliminated from the American scene, a very large number of people would suddenly find themselves medically indigent in event of any important medical emergency.

Why should Congress be asked to attack a problem of specific, identifiable need for those citizens over 65 by means of a program that would cover everyone of this age—irrespective of need—and yet fall tragically short of matching or equaling the benefit programs which it would displace?

Furthermore, the provisions of HR 3920 are costly even in terms of the limited benefits the bill proposes to offer. We concur with those who have informed your committee that the ultimate cost of this limited program is totally unpredictable. Competent authorities maintain that the proposed additional tax would not be sufficient to finance the benefits offered, and we have seen no evidence to the contrary.

If HR 3920 is enacted, it will inevitably and necessarily be only the first step toward a comprehensive program of federal health insurance. Friend and foe of HR 3920 both acknowledge this fact. Before long, Congress would certainly be asked to extend this limited program by making provision for the payment of surgical and medical services for the aged. As has been the history of all other elements of the Social Security Program, every Congressional session will be urged to expand this program. And the force of the argument to support the extension of federally operated medical care programs will be enhanced to the extent that the vitality of the voluntary system has been sapped by ill-conceived governmental intervention in the provision of health care.

The government irreparably injures the public interest if it sets up a program which will inhibit further growth and development of the voluntary plans, and perhaps ultimately nullify their contribution to the health and welfare of the entire population.

In our statement before this committee two years ago, the National Association of Blue Shield Plans suggested that "some arrangement whereby voluntary organizations can be utilized by government to provide health care for the needy might well be the answer." In our opinion, Congress has provided an instrument, in the Kerr-Mills Program, which if improved and fully implemented, is the best answer yet evolved for the specific problems of our aged and needy citizens.

We can demonstrate the practicality of utilizing Blue Shield Plans as underwriters of the services to be provided the needy elder citizens through the Kerr-Mills Program. We in Blue Shield would welcome a much broader opportunity to make our contribution to this program.

The Kerr-Mills Program is essentially right. It can provide medical care assistance where and when it is needed. It can provide a comprehensive scope of care. It can provide the kind of care that a patient needs and to the full extent that he needs it. Its cost

is supported by the entire community instead of being loaded upon the wage earner, as in HR 3920.

And the Kerr-Mills Program can be improved. It can be amended in such a way as to promote and encourage the use of the voluntary, nonprofit prepayment plans for underwriting the benefit program. This would permit needy elderly people to avail themselves of the services of their own freely chosen physicians and hospitals without a "means test" at the time when these services are needed.

By adapting Kerr-Mills to the voluntary prepayment structure, Congress not only would strengthen the Kerr-Mills Program, but it would also make a tremendous contribution to the security and strength of America's entire voluntary health insurance program. Thus, it would enhance the value and usefulness of the voluntary prepayment program for *all* the citizens of the United States who are now or should become its beneficiaries. By utilizing the prepayment plans, Congress would also achieve a stability and a predictability of cost for the Kerr-Mills program that is obtainable in no other way.

The voluntary prepayment system, of which Blue Shield is a major part, has proved that it can do a satisfactory job for a very large proportion of the population, including a majority of the very people whom HR 3920 is designed to serve. We believe that Congress can best serve the interests of all the people of the United States by making the fullest possible use of the existing prepayment system to underwrite the medical care needs for all those segments of the population for whose aid or support our government has a legitimate role.

We in Blue Shield would welcome any opportunity to aid and advise Congress in any plans to accomplish this objective.

As a means of effecting the improvement of the Kerr-Mills Program, through maximum utilization of the established nonprofit, voluntary prepayment plan, we recommend that Congress consider amending the Social Security Laws to accomplish the following objectives:

1. Provide for a clear separation of the MAA program from the OAA program, and for professional medical control and guidance of the MAA program.

2. Direct the Secretary of HEW to fulfill the intent of Congress in making maximal use of established prepayment plans to underwrite the MAA program in the various states, in order to stabilize the costs of this program, to minimize its welfare aspects, and to eliminate the means test at the time when medical care is required.

To recapitulate our presentation to your committee, Mr. Chairman, I would offer the following summary observations:

Blue Shield Plans, created and developed by the local physicians in cooperation with labor, industry, and community leaders throughout the United States, have long been aware of the special needs of older citizens for medical care, and for the economic means of obtaining such care.

Approximately 4 million citizens in the over 65 age group are now enrolled in Blue Shield Plans, and Blue Shield members under 65 have the privilege of continuing their Blue Shield coverage after reaching the 65 year mark.

Blue Shield members over 65 now represent more than 8% of the entire Blue Shield enrollment, and enrollment of over 65 subscribers is growing four time as fast as our total enrollment. The great majority of these elderly Blue Shield members are entitled to covered medical services on a prepaid basis, without additional cost for such services.

Our experience convinces us that the problem of providing medical care for the elderly is in process of solution, largely through voluntary methods, supplemented by such programs as the Kerr-Mills Act, and that its solution would be hastened by utilizing the Kerr-Mills mechanism with whatever additional direction is necessary, and by using the voluntary prepayment plans to underwrite prepaid programs for the needy aged.

We take reasonable pride in the accomplishments of Blue Shield—accomplishments largely to be credited to the medical profession and the community leaders who together have created and guided Blue Shield.

Rather than setting up an inadequate program for everyone who has attained a certain age—regardless of his need for it—we urge that Congress build upon the solid foundations of legislative enactment represented by the Kerr-Mills Program, and of voluntary initiative represented by Blue Shield and its companion hospital plan, Blue Cross. We urge that Congress take advantage of the knowledge and experience of the voluntary prepayment plans to strengthen the Medical Aid to the Aged program. By doing so, we submit that Congress would discharge its public responsibility to the aged and it would also greatly contribute to the ultimate success of America's voluntary prepayment plans in serving the medical needs of the entire community.